Medical Assistance Provider Bulletin

Attention: All Title XIX Certified Rehabilitation Agencies

Subject: New Claim Form; Place of Service, Type of Service and HCPCS Codes; and New Prior Authorization Request Form

Date: September 1, 1987

Code: MAPB-087-016-D

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This bulletin contains important information on the following:

This bulletin should be used in conjunction with the All Provider Bulletin, MAPB-087-037-X, dated September 1, 1987.

I. INTRODUCTION

The Wisconsin Medical Assistance Program (WMAP) has signed a new fiscal agent contract with E.D.S. Federal Corporation (EDS). Under this new contract, there will be major enhancements in the processing of Medical Assistance claims received by EDS on or after January 1, 1988. These enhancements are discussed in detail in the above referenced All Provider Bulletin.

Wisconsin Department of Health and Social Services, Division of Health, Bureau of Health Care Financing, Provider/Recipient Services, P.O. Box 309, Madison, Wisconsin 53701

In addition to the changes resulting from the new contract with EDS, the Health Care Financing Administration (HCFA) has mandated that all State Medical Assistance agencies implement use of a new claim form, the National Health Insurance Claim Form, HCFA 1500. The WMAP is implementing use of the National HCFA 1500 claim form for most providers. Many providers already use the Wisconsin version of the HCFA 1500 claim form to bill the WMAP and some are using the National HCFA 1500 claim form to bill Medicare and other third party payors. To facilitate consistent billing procedures, the WMAP is implementing the National HCFA 1500 claim form and national and local Place of Service and Type of Service codes.

Concurrent with the claim form change, the WMAP is also implementing the HCFA Common Procedure Coding System (HCPCS) currently used by Medicare. Use of HCPCS codes is also federally mandated.

NOTE: Due to the above mentioned changes, EDS will be converting the claims processing system at the end of 1987. Providers are advised to submit to EDS for receipt by no later than December 24, 1987, all claims, adjustments and prior authorization requests which are completed in accordance with billing instructions and claim forms in use in 1987. EDS will return, unprocessed, any claims received after December 24 which are in the 1987 format.

Past experience has shown that delivery of claims mailed during the holiday season is delayed due to heavy holiday mail. Please allow ample mailing time to ensure that claims mailed in 1987 are received no later than December 24. If there is a likely possibility that claims prepared and mailed in late December will not be received by EDS by December 24, it may be to the provider's advantage to hold such claims and mail them in the new format on or after January 1, 1988.

Providers are also advised that no checks will be issued on January 3, 1988. Claims which would have finalized processing during that week will appear on the following week's Remittance and Status Report.

II. PROVIDER BILLING WORKSHOPS

EDS is conducting provider workshops which focus on the WMAP requirements for the National HCFA 1500 claim form. These workshops are intended for billing personnel. See Attachment 10 for times and locations in your area.

III. NATIONAL HEALTH INSURANCE CLAIM FORM - HCFA 1500

All Rehabilitation Agencies are required to use the National HCFA 1500 claim form for all claims received by EDS on or after January 1, 1988. Claims, including resubmission of any previously denied claims, received on a form other than the National HCFA 1500 claim form will be denied by EDS. Modifications to or use of modified versions of the National HCFA 1500 claim form may also result in claims denial.

A sample claim form and detailed billing instructions are included in Attachments 1 and 2 of this bulletin. Effective January 1, 1988, these instructions should be used to replace those currently included in the Rehabilitation Agency Provider Handbook, Part P, Division III, dated July 1, 1984. Providers should pay special attention to the following areas on the National HCFA 1500 claim form itself and to the changes in the type of information required for completion of the claim form.

1. Program Block (Claim Sort Indicator). A new element, the claim sort indicator, must be entered in the program block for Medicaid which is located on the top line of the claim form. This indicator identifies the general kinds of services being billed and is essential to processing of the claim form by EDS. Claim sort indicators for each type of service are included in the billing instructions. The sample claim form included in Attachment 1 indicates where on the claim form this information is to be entered. Claims received on or after January 1, 1988 without this claim sort indicator will be denied.

2. Element 1. The recipient's last name is required first, then the first name, and middle initial.

3. Element 6. The 10 digit Medical Assistance Recipient Identification Number must be entered.

4. Element 9. Revised "Other Insurance" (OI) disclaimer codes, identified in the claim form completion instructions, must be entered in this element.

5. Element 10. This is an addition to the element which requests "other" accident information.

6. Element 11. Medicare disclaimer codes, identified in the claim form completion instructions, must be entered in this element.

7. Element 24. There are two (2) fewer line items than on the current HCFA 1500 claim form.

8. Element 24H. Recipient spenddown amount, when applicable, must be entered in this element.

Providers should reference the All Provider Bulletin, MAPB-087-037-X, dated September 1, 1987, for additional details on claims processing changes.

Effective January 1, 1988, the National HCFA 1500 claim form will not be provided by either the WMAP or EDS. It is a national form that can be obtained at the provider's expense from a number of forms suppliers and other sources. One such source is:

State Medical Society Services, Inc.
P.O. Box 1109
MADISON WI 53701

(608) 257-6781 (Madison area)
1-800-362-9080 (Toll free)

IV. PLACE OF SERVICE CODES

Claims received by EDS on or after January 1, 1988 must include national place of service (POS) codes in element #24B on the National HCFA 1500 claim form. Claims/adjustments submitted without POS codes or with incorrect POS codes will be denied. POS codes are listed on the back of the claim form. Allowable POS codes for Rehabilitation Agencies are included in Attachment 4.

V. TYPE OF SERVICE CODES

Effective January 1, 1988, the WMAP is converting currently used type of service (TOS) codes to coincide with the National TOS codes, which are located on the back of the National HCFA 1500 claim form, and with the additional codes used by Medicare and the WMAP. All providers are required to indicate the appropriate TOS code in element 24G on the claim form for each line item billed on all claims received on or after January 1, 1988. Claims/adjustments submitted without TOS codes will be denied. Claims/adjustments submitted with incorrect TOS codes are subject to incorrect reimbursement or denial. Allowable TOS codes for Rehabilitation Agencies are included in Attachment 4.

VI. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

The Health Care Financing Administration has also mandated state Medical Assistance agencies to use HCPCS. HCPCS is a procedure coding system that is currently used by Medicare.

HCPCS codes are composed of:

- Physician's Current Procedural Terminology - Fourth Edition (CPT-4) codes which are updated annually;
- Nationally assigned codes which are five (5) characters in length (alpha/numeric) and begin with any of the alpha characters A through V, e.g., A1234 - V5678; and
- Codes locally assigned by the WMAP or the Medicare Intermediary which are five (5) characters in length (alpha/numeric), and begin with the alpha characters W through Z, e.g., W1111 - Z9999.

HCPCS codes and their narrative descriptions are required on all claims/adjustments received by EDS on or after January 1, 1988. Claims/adjustments submitted without HCPCS codes and narrative descriptions will be denied. Allowable HCPCS codes and their descriptions for Rehabilitation Agencies are listed in Attachment 3.

VII. PRIOR AUTHORIZATION REQUEST FORM

The WMAP has developed a standard prior authorization (PA) request cover form for use by most providers. All Rehabilitation Agencies are required to use this form for all PA requests received by EDS on or after January 1, 1988.

The prior authorization request consists of two (2) parts, the standard prior authorization form, PA/RF, and the service specific attachment. Rehabilitation Agencies must request prior authorization for therapy services on the standard form, PA/RF, and on the therapy attachment, form PA/TA.

Spell of Illness requests must be requested on the standard form, PA/RF, and the Spell of Illness attachment for physical, occupational and speech therapy, form PA/SOIA. Prior authorization requests received on any other forms will be returned to the provider.

A Prior Authorization Request Form and Usage Table is included in Attachment 5.

Sample Prior Authorization request forms and detailed instructions for completing them are included in Attachments as follows:

	Attachment Numbers
Form PA/RF and Completion Instructions	6 - 6c
Form PA/TA and Completion Instructions	7 - 7c
Form PA/RF for Spell of Illness and Completion Instructions	8 - 8c
Form PA/SOIA and Completion Instructions	9 - 9d

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Appendix 1a
National HCFA 1500 Claim Form Sample
(Rehabilitation Agency)

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) M | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A.

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY | SEX: M X | F

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown | STATE: WI

8. PATIENT STATUS: Single | Married | Other | Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE: 55555 | TELEPHONE (Include Area Code): (XXX) XXX-XXXX

ZIP CODE | TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-P

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: M-7

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M | F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M | F

b. AUTO ACCIDENT? YES | NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO — If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY — FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: I.M. Referring MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: B12345

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY — FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 435.9
2. 437.0
3.
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 1234567

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 02 03 95	06 08 95	7	1	97116	PT	1	XX XX	8.0				
2 02 23 95		7	1	97110	PT	2	XX XX	1.0				
3 02 01 95		7	1	97265	PT	1	XX XX	2.0				
4												
5												
6												Recipient Spenddown

25. FEDERAL TAX I.D. NUMBER: SSN | EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE: $ XXX.XX

29. AMOUNT PAID: $ XX.XX

30. BALANCE DUE: $ XX.XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I.M. Provider MM/DD/YY

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

I.M. Nursing Home
506 Willow
Anytown, WI 55555

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Billing
1 W. Williams
Anytown, WI 55555 87654300

PIN# GRP#

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

Appendix 1b
National HCFA 1500 Claim Form Completion Instructions for Physical Therapy Services and Rehabilitation Agencies

Use these claim form completion instructions to avoid denial or inaccurate claim payment. Enter all required data on the claim form in the appropriate element. Include attachments only when requested. All elements are required unless "not required" is specified.

Medicaid recipients receive an identification card when initially enrolled into Wisconsin Medicaid and at the beginning of each following month. Providers must always see this card before providing services. Please use the information exactly as it appears on the identification card to complete the patient and insured information.

Element 1 - Program Block/Claim Sort Indicator
Enter the claim sort indicator:

"T" - Physical Therapy Services.
"M" - Rehabilitation Agency.

Claims submitted without this indicator are denied.

Element 1a - Insured's I.D. Number
Enter the recipient's 10-digit identification number from the current identification card. This element must contain no other numbers, unless the claim is a Medicare crossover claim. In this case, the recipient's Medicare number may also be indicated.

Element 2 - Patient's Name
Enter the recipient's last name, first name, and middle initial from the current identification card.

Element 3 - Patient's Birth Date, Patient's Sex
Enter the recipient's birth date in MM/DD/YY format (i.e., February 3, 1955, would be 02/03/55) from the identification card. Specify if male or female with an "X."

Element 4 - Insured's Name (not required)

Element 5 - Patient's Address
Enter the complete address of the recipient's place of residence.

Element 6 - Patient Relationship to Insured (not required)

Element 7 - Insured's Address (not required)

Element 8 - Patient Status (not required)

Element 9 - Other Insured's Name
Bill health insurance (commercial insurance coverage) before billing Wisconsin Medicaid unless the service does not require health insurance billing according to Appendix 18a of Part A, the all-provider handbook.

✓ Leave this element blank when the provider has not billed the other health insurance because the "Other Coverage" of the recipient's identification card is blank, the service does not require health insurance billing according to Appendix 18a of Part A, the all-provider handbook, or the recipient's identification card indicates "DEN" only.

✓ When "Other Coverage" of the recipient's identification card indicates HPP, BLU, WPS, CHA, or OTH, and the service requires health insurance billing according to Appendix 18a of Part A, the all-provider handbook, one of the following codes MUST be indicated in the *first* box of element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID in part by the health insurance. The amount paid by the health insurance to the provider or the insured is indicated on the claim.
OI-D	DENIED by the health insurance company following submission of a correct and complete claim or payment was applied towards the coinsurance and deductible. Do NOT use this code unless the claim in question was actually billed to and denied by the health insurer.
OI-Y	YES, the card indicates other coverage but it was not billed for reasons including, but not limited to the following: ➔ Recipient denies coverage or will not cooperate. ➔ The provider knows the service in question is noncovered by the carrier. ➔ The health insurance failed to respond to initial and follow-up claim. ➔ Benefits not assignable or cannot get an assignment.

✓ When "Other Coverage" of the recipient's identification card indicates "HMO" or "HMP", indicate one of the following disclaimer codes, if applicable.

Code	Description
OI-P	PAID by HMO or HMP. The amount paid is entered on the claim.
OI-H	HMO or HMP does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.

Note: The provider may *not* use OI-H if the HMO or HMP denied payment because an otherwise covered service was not provided by a designated provider. Wisconsin Medicaid does not pay for services covered by an HMO or HMP except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill Wisconsin Medicaid for services which are included in the capitation payment.

Element 10 - Is Patient's Condition Related to (not required)

Element 11 - Insured's Policy, Group, or FECA Number

Use the *first* box of this element for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Medicare must be billed before billing Wisconsin Medicaid. When the recipient's identification card indicates Medicare coverage, but Medicare does not pay, indicate one of the following Medicare disclaimer codes. The description is not required.

Code	*Description*
M-1	Medicare benefits exhausted. This code applies when Medicare has denied the claim because the recipient's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted.

Use M-1 in these two instances only:

For Medicare Part A (all three criteria must be met):
- The provider is certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The procedure provided is covered by Medicare Part A but is denied due to benefits being exhausted.

For Medicare Part B (all three criteria must be met):
- The provider is certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The procedure provided is covered by Medicare Part B but is denied due to benefits being exhausted.

M-5 Provider not Medicare-certified. This code applies when the provider is not required by Wisconsin Medicaid to be Medicare Part A or Part B certified, has chosen not to be Medicare Part A or Part B certified or cannot be Medicare Part A or Part B certified.

Use M-5 in these two instances only:

For Medicare Part A (all three criteria must be met):
- The provider is not certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The service is covered by Medicare Part A.

For Medicare Part B (all three criteria must be met):
- The provider is not certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service is covered by Medicare Part B.

M-6 Recipient not Medicare-eligible. This code applies when Medicare denied the claim because there is no record of the recipient's eligibility. Use M-6 in these two instances only:

For Medicare Part A (all three criteria must be met):
- The provider is certified for Medicare Part A.
- The service is covered by Medicare Part A.
- The recipient is not eligible for Medicare Part A.

For Medicare Part B (all three criteria must be met):
- The provider is certified for Medicare Part B.
- The service is covered by Medicare Part B.
- The recipient is not eligible for Medicare Part B.

M-7 Medicare disallowed or denied payment. This code applies when Medicare actually denies the claim for reasons given on the Medicare remittance advice. Use M-7 in these two instances only:

For Medicare Part A (all three criteria must be met):
- The provider is certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The service is covered by Medicare Part A, but is denied by Medicare Part A.

For Medicare Part B (all three criteria must be met):
- The provider is certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service is covered by Medicare Part B, but is denied by Medicare.

M-8 Noncovered Medicare service. This code applies when Medicare was not billed because Medicare does not cover the service at this time. A list of services that are not covered under Medicare is in Appendix 16 of Part A, the all-provider handbook.

Nursing homes must use M-8 for Medicare-eligible recipients who are hospitalized and do not wish to return to a Medicare-covered bed.

For Medicare Part A (all three criteria must be met):
- The provider is certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The service is not covered under Medicare Part A.

For Medicare Part B (all three criteria must be met):
- The provider is certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service is not covered under Medicare Part B.

Leave the element blank if Medicare is not billed because the recipient's Medicaid identification card indicated no Medicare coverage.

Leave the element blank if Medicare allows an amount on the recipient's claim. Attach the Explanation of Medicare Benefits (EOMB) to the claim. Do not enter Medicare paid amounts on the claim form. Refer to Appendix 17 of Part A, the all-provider handbook, for more information about the submission of claims for dual-entitlees.

Elements 12 and 13 - Authorized Person's Signature
(Not required since the provider automatically accepts assignment through Medicaid certification.)

Element 14 - Date of Current Illness, Injury, or Pregnancy (not required)

Element 15 - If Patient Has Had Same or Similar Illness (not required)

Element 16 - Dates Patient Unable to Work in Current Occupation (not required)

Element 17 - Name of Referring Physician or Other Source
Enter the referring or prescribing physician's name.

Element 17a - I.D. Number of Referring Physician
Enter the referring provider's six-character UPIN number. If the UPIN number is not available, enter the Medicaid provider number or license number of the referring provider. Refer to Appendix 3 of Part A, the all-provider handbook, for the UPIN directory address.

Element 18 - Hospitalization Dates Related to Current Services (not required)

Element 19 - Reserved for Local Use
If an unlisted procedure code is billed, describe the procedure. If element 19 does not provide enough space for the procedure description, or if multiple unlisted procedure codes are being billed, attach documentation to the claim describing the procedure(s). In this instance, indicate "See Attachment" in element 19.

Element 20 - Outside Lab (not required)

Element 21 - Diagnosis or Nature of Illness or Injury
Enter *the International Classification of Disease* (ICD) diagnosis code for each symptom or condition related to the services provided. Manifestation ("M") codes are not acceptable. List the primary diagnosis first. Etiology ("E") codes may not be used as a primary diagnosis. The diagnosis description is not required.

Element 22 - Medicaid Resubmission (not required)

Element 23 - Prior Authorization

Enter the seven-digit prior authorization number from the approved prior authorization request form. Bill services authorized under multiple prior authorizations on separate claim forms with their respective prior authorization numbers.

Element 24a - Date(s) of Service

Enter the month, day, and year for each procedure using the following guidelines.

✓ When billing for one date of service, enter the date in MM/DD/YY format in the "From" field.

✓ When billing for two, three, or four dates of service on the same line, enter the first date of service in MM/DD/YY format in the "From" field, and subsequent dates of service in the "To" field by listing *only* the date(s) of the month (e.g., DD, DD/DD, or DD/DD/DD).

It is allowable to enter up to four dates of service per line if all of the following apply:

✓ All dates of service are in the same calendar month.
✓ All services are billed using the same procedure code and modifier, if applicable.
✓ All procedures have the same type of service code.
✓ All procedures have the same place of service code.
✓ All procedures were performed by the same provider.
✓ The same diagnosis is applicable for each procedure.
✓ The charge for each procedure is identical. (Enter the total charge *per detail line* in element 24f.)
✓ The number of services performed on each date of service is identical.
✓ All procedures have the same HealthCheck indicator.
✓ All procedures have the same emergency indicator.

Element 24b - Place of Service

Enter the appropriate *single-digit* place of service code for each service. Refer to Appendix 3 of this handbook for a list of allowable place of service codes for physical therapy services.

Element 24c - Type of Service Code

Enter the appropriate single-digit type of service code. Refer to Appendix 3 of this handbook for a list of allowable type of service codes for physical therapy services.

Element 24d - Procedures, Services, or Supplies

Enter the appropriate five-character procedure code and, if applicable, a maximum of two, two-character modifiers. Refer to Appendix 3 of this handbook for a list of allowable procedure codes for physical therapy services.

Element 24e - Diagnosis Code

When multiple procedures related to different diagnoses are submitted, use column E to relate the procedure performed (element 24d) to a specific diagnosis in element 21. Enter the number (1, 2, 3, or 4) which corresponds to the appropriate diagnosis in element 21.

Element 24f - Charges

Enter the total charge for each line.

Element 24g - Days or Units

Enter the total number of services billed for each line. Physical therapy services must be billed following the *Conversion of Therapy Treatment Time Guidelines* in Appendix 5 of this handbook.

Element 24h - EPSDT/Family Planning
Enter an "H" for each procedure that was performed as a result of a HealthCheck (EPSDT) referral. If HealthCheck does not apply, leave this element blank.

Element 24i - EMG
Enter an "E" for *each* procedure performed as an emergency, regardless of the place of service. If the service is not an emergency, leave this element blank.

Element 24j - COB (not required)

Element 24k - Reserved for Local Use
Enter the eight-digit provider number of the performing provider *for each procedure*, if it is different than the billing provider number indicated in element 33.

Note: Rehabilitation agencies do not indicate a performing provider number.

When applicable, enter the word "spenddown" and under it, enter the spenddown amount on the last detail line of element 24k directly above element 30. Refer to Section IX of Part A, the all-provider handbook, for information on recipient spenddown.

Any other information entered in this column may cause claim denial.

Element 25 - Federal Tax ID Number (not required)

Element 26 - Patient's Account No.
Optional - The provider may enter up to 12 characters of the patient's internal office account number. This number appears on the fiscal agent Remittance and Status Report.

Element 27 - Accept Assignment
(Not required, provider automatically accepts assignment through Medicaid certification.)

Element 28 - Total Charge
Enter the total charges for this claim.

Element 29 - Amount Paid
Enter the amount paid by the health insurance. If the other health insurance denied the claim, enter $0.00. (If a dollar amount is indicated in element 29, "OI-P" must be indicated in element 9.)

Element 30 - Balance Due
Enter the balance due as determined by subtracting the recipient spenddown amount in element 24k and the amount paid in element 29 from the amount in element 28.

Element 31 - Signature of Physician or Supplier
The provider or an authorized representative must sign in element 31. Also enter the month, day, and year the form is signed in MM/DD/YY format.

Note: This may be a computer-printed or typed name and date or a signature stamp with the date.

Element 32 - Name and Address of Facility Where Services Rendered
If the services were provided to a recipient in a nursing home (place of service 7 or 8), indicate the nursing home's eight-digit provider number.

Element 33 - Physician's, Supplier's Billing Name, Address, Zip Code, and Telephone
Enter the billing provider's name (exactly as indicated on the provider's notification of certification letter) and address. At the bottom of element 33, enter the billing provider's eight-digit provider number.

ATTACHMENT 3

HCPCS PROCEDURE CODE AND COPAYMENT CONVERSION TABLE FOR REHABILITATION AGENCY SERVICES

The HCFA Common Procedure Code System (HCPCS) is required for claims submitted on and after January 1, 1988. Please refer to the following table. Copayment amounts for services provided for less than 30 minutes should be prorated.

PROCEDURE CODE		MOD.	NEW DESCRIPTION	COPAYMENT
PRIOR TO 01/01/88	EFFECTIVE 01/01/88			
97700	97700	n/a	Evaluation P.T.	$1.00/ 30 minutes
97000	97000	n/a	Physical Therapy Treatment 30 minutes	$1.00/ 30 minutes
97100	97100	n/a	Physical Therapy Treatment 30 minutes	$1.00/ 30 minutes
97200	97200	n/a	Physical Therapy Treatment 30 minutes	$1.00/ 30 minutes
09509	W9509	n/a	Evaluation/Re-evaluation O.T. 30 minutes	$1.00/ 30 minutes
09512	W9512	n/a	Group Occupational Therapy (30 minute segment)	$1.00/ 30 minutes
09520	W9520	n/a	Social Inter. and Psych. Intrapersonal Skills	$1.00/ 30 minutes
09522	W9522	n/a	Group Social Inter. and Psych. Intrapersonal Skills (each 30 minute segment per person)	$1.00/ 30 minutes
09523	W9523	n/a	Motor Skills 30 minutes	$1.00/ 30 minutes
09525	W9525	n/a	Sensory Integrative Skills 30 minutes	$1.00/ 30 minutes
09527	W9527	n/a	Cognitive Skills 30 minutes	$1.00/ 30 minutes
09529	W9529	n/a	Activities of Daily Living Skills 30 minutes	$1.00/ 30 minutes
09531	W9531	n/a	Preventive Skills 30 minutes	$1.00/ 30 minute

ATTACHMENT 3

HCPCS PROCEDURE CODE AND COPAYMENT CONVERSION TABLE FOR REHABILITATION AGENCY SERVICES

PROCEDURE CODE		MOD.	NEW DESCRIPTION	COPAYMENT
PRIOR TO 01/01/88	EFFECTIVE 01/01/88			
09533	W9533	n/a	Therapeutic Adaptions 30 minutes	$1.00/ 30 minute
92506	92506	n/a	Speech/Language Evalutation 30 minutes	$1.00/ 30 minute
92507	92507	n/a	Speech/Language Therapy 30 minutes	$1.00/ 30 minute
92508	92508	n/a	Group Speech/Language Therapy (each 30 minute segment per person)	$1.00/ 30 minute

ATTACHMENT 4

REHABILITATION AGENCY SERVICES

* *

PLACE OF SERVICE (POS) CONVERSION TABLE

Prior to 01/01/88	Effective 01/01/88	New Description
1	3	Office
2	4	Home
4	7	Nursing Home
4	8	Skilled Nursing Facility

TYPE OF SERVICE (TOS) CONVERSION TABLE

Prior to 01/01/88	Effective 01/01/88	New Description
9	9	Rehabilitation Services

PRIOR AUTHORIZATION REQUEST FORMS AND USAGE

All requests for prior authorization received on and after January 1, 1988 must be submitted on the following revised forms. Refer to the following chart for the appropriate request and attachment forms to be used when requesting authorization for specific services.

Service	Prior Authorization Form Required	Special Consideration
Chiropractic	Prior Authorization Request Form (PA/RF) & Chiropractic (PA/CA)	Use when requesting prior authorization to extend treatment beyond twenty manipulations per spell of illness.
Dental/Orthodontia	Dental Prior Authorization Request Form (PA/DRF) & Dental Services Attachment (PA/DA)	Do <u>not</u> complete PA/DA if requesting orthodontic services.
	Dental Prior Authorization Request Form (PA/DRF) & Orthodontic Services Attachment (PA/OA)	Use to report orthodontic services <u>only</u>.
Drug DME DMS (includes PT, OT, Speech and Home Health DME)	Prior Authorization Request Form (PA/RF) & Drug/Disposable Medical Supplies Attachment (PA/DGA)	- Use to request any drug requiring prior authorization. - Use to request disposable medical supply item requiring prior authorization.
	Prior Authorization Request Form (PA/RF) & Durable Medical Equipment (PA/DMEA)	Use to request any DME item requiring prior authorization.
Hearing Aid	Physicians Otological Report (PA/OF)	Must be completed by referring physician. Audiologist must submit PA/OF with PA/ARF1 and PA/ARF2 when requesting authorization for hearing aid(s).

Prior Authorization
Request Forms and Usage
Page 2

Service	Prior Authorization Form Required	Special Consideration
Hearing Aid (continued)	Audiological Report for Hearing Aid Request (PA/ARF1) & Hearing Aid Request Form (PA/ARF2)	Audiologists uses PA/ARF1 and PA/ARF2 to request hearing aid (must also include PA/OF).
Home Health (includes Independent Nurses)	Prior Authorization Request Form (PA/RF) & Home Health Attachment (PA/HHSA)	- Use to request home health aide/RN/LPN services provided by a home health agency. - Use to request nursing services provided by RN/LPN in independent practice.
	Prior Authorization Request Form (PA/RF) & Home Health Attachment (PA/HHTA)	- Use to request therapy (PT, OT, Speech) services provided by a home health agency.
Hospital	Prior Authorization Request Form (PA/RF) & Physician Attachment (PA/PA)	Use when requesting prior authorization for - transplants - AIDS services - ventilator services
Mental Health	Prior Authorization Request Form (PA/RF) & Psychotherapy Attachment (PA/PSYA)	Use to request all psychotherapy services requiring prior authorization.

NOTE:

1. If recipient will receive only home health therapy services, attach to the Prior Authorization Request Form (PA/RF) and submit to EDS.

2. If recipient will receive home health services in addition to home health therapy services, attach both attachment forms (PA/HHSA and PA/HHTA) to the Prior Authorization Request Form (PA/RF) and submit to EDS.

Prior Authorization
Request Forms and Usage
Page 3

Service	Prior Authorization Form Required	Special Consideration
Mental Health (continued)	Prior Authorization Request Form (PA/RF) & AODA Attachment (PA/AA) (Alcohol and Other Drug Abuse)	Use to request all AODA services requiring prior authorization.
	Prior Authorization Request Form (PA/RF) & Day Treatment Attachment (PA/DTA)	Use to request day treatment services requiring prior authorization.
Out-of-State	Prior Authorization Request Form (PA/RF) & Physician Attachment (PA/PA)	Use when requesting out-of-state nursing home services (process type 999).
Personal Care	Prior Authorization Request Form (PA/RF) & Personal Care Attachment (PA/PCA)	Use to request any personal care services requiring prior authorization.
Physician (includes family planning and rural health clinics)	Prior Authorization Request Form (PA/RF) & Physician Attachment (PA/PA)	Use when requesting any physician service requiring prior authorization.
Therapy (includes Rehabilitation Agencies)	Prior Authorization Request Form (PA/RF) & Therapy Attachment (PA/TA) (physical, occupational, speech and audiological)	Do not complete PA/TA when requesting a spell of illness (complete PA/SOI). Use PA/TA when requesting prior authorization to extend treatment beyond forty-five treatment days for the <u>same</u> spell of illness.
	Prior Authorization Request Form (PA/RF) & Spell of Illness Attachment (PA/SOI) (physical, occupational, speech)	Use to request a new spell of illness <u>only</u>.

Prior Authorization
Request Forms and Usage
Page 4

Service	Prior Authorization Form Required	Special Consideration
Transportation	Prior Authorization Request Form (PA/RF) & Physician Attachment (PA/PA)	Use when requesting any transportation service requiring prior authorization (process type 999).
Vision	Prior Authorization Request Form (PA/RF) & Vision Attachment (PA/VA)	Use to request any vision service requiring prior authorization.

The timely determination of authorization is significantly enhanced by the completeness and quality of the documentation submitted by providers when requesting prior authorization. Carefully complete the Prior Authorization Request Form (PA/RF), attach appropriate prior authorization attachment form and submit to the following address:

E.D.S. Federal Corporation
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

INSTRUCTIONS FOR THE COMPLETION OF THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

ELEMENT 1 - PROCESSING TYPE
Enter the appropriate three digit processing type from the attached table. The 'process type' is a three digit code used to identify the type of service requested. Use 999 - 'Other' only if the request cannot reference any of the process types listed. Prior Authorization/Spell of Illness requests will be returned without adjudication if no processing type is indicated.

**111 - Physical Therapy
**112 - Occupational Therapy
**113 - Speech Therapy/Audiology
**114 - Physical Therapy (spell of illness only)
**115 - Occupational Therapy (spell of illness only)
**116 - Speech Therapy (spell of illness only)
117 - Physician Services (includes Family Planning and Rural Health)
118 - Chiropractic
*120 - Home Health/Independent Nurses Services/Home Health Therapy
121 - Personal Care Services
122 - Vision
126 - Psychotherapy (HCFA 1500 billing providers only)
127 - Psychotherapy (UB82 billing providers only)
128 - AODA Services
129 - Day Treatment Services
130 - Durable Medical Equipment
131 - Drugs
132 - Disposable Medical Supplies
133 - Transplant Services
134 - AIDS Services (hospital and nursing home)
135 - Ventilator Services (hospital and nursing home)
999 - Other (use only if the request cannot reference any of the processing types listed)

* Includes PT, OT, Speech
** Includes Rehabilitation Agencies

ELEMENT 2 - RECIPIENT'S MEDICAL ASSISTANCE IDENTIFICATION NUMBER
Enter the ten digit medical assistance recipient number as found on the recipient's medical assistance identification card.

ELEMENT 3 - RECIPIENT'S NAME
Enter the recipient's last name, followed by first name and middle initial, exactly as it appears on the recipient's medical assistance identification card.

ELEMENT 4 - RECIPIENT'S ADDRESS
Enter the address of the recipient's <u>place of residence</u>, <u>the street, city, state and zip code must be included</u>. If the recipient is a resident of a nursing home or other facility, also include the name of the nursing home or facility.

ELEMENT 5 - RECIPIENT'S DATE OF BIRTH
Enter the recipient's date of birth in MM/DD/YY format (i.e., June 8, 1941 would be 06/08/41), as it appears on the recipient's medical assistance identification card.

ELEMENT 6 - RECIPIENT'S SEX
Enter an 'X' to specify male or female.

ELEMENT 7 - BILLING PROVIDER'S NAME, ADDRESS AND ZIP CODE
Enter the name and complete address (street, city, state and zip code) of the billing provider. No other information should be entered in this element, as this element also serves as your return address label.

ELEMENT 8 - BILLING PROVIDER'S TELEPHONE NUMBER
Enter the telephone number, including the area code, of the office, clinic, facility or place of business of the billing provider.

ELEMENT 9 - BILLING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER
Enter the eight digit WMAP provider number of the billing provider.

ELEMENT 10 - RECIPIENT'S PRIMARY DIAGNOSIS
Enter the appropriate International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis code and description most relevant to the service/procedure requested.

> **NOTE:**
> Pharmacists, medical vendors and individual medical suppliers may provide a written description only.

ELEMENT 11 - RECIPIENT'S SECONDARY DIAGNOSIS
Enter the appropriate International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis code and description additionally descriptive of the recipient's clinical condition.

> **NOTE:**
> Pharmacists, medical vendors and individual medical suppliers may provide a written description only.

ELEMENT 12 - START DATE OF SPELL OF ILLNESS*
DO NOT COMPLETE THIS ELEMENT UNLESS REQUESTING A THERAPY (PT, OT, SPEECH) SPELL OF ILLNESS. Enter the date of onset for the spell of illness in MM/DD/YY format (i.e., March 1, 1988 would be 03/01/88).

* Therapy spell of illness requests only.

ELEMENT 13 - FIRST DATE OF TREATMENT*
DO NOT COMPLETE THIS ELEMENT UNLESS REQUESTING A THERAPY (PT, OT, SPEECH) SPELL OF ILLNESS. Enter the date of the first treatment for the spell of illness in MM/DD/YY format (i.e., March 1, 1988 would be 03/01/88).

* Therapy spell of illness requests only.

ELEMENT 14 - PROCEDURE CODE(S)
Enter the appropriate revenue, HCPCS or national drug code (NDC) procedure code for each service/procedure/item requested, in this element. DO NOT COMPLETE THIS ELEMENT IF REQUESTING A THERAPY (PT, OT, SPEECH) SPELL OF ILLNESS.

ELEMENT 15 - MODIFIER
Enter the modifier for the procedure code (if a modifier is required by Bureau of Health Care Financing policy and the coding structure used) for each service/procedure/item requested. DO NOT COMPLETE THIS ELEMENT IF REQUESTING A THERAPY (PT, OT, SPEECH) SPELL OF ILLNESS.

ELEMENT 16 - PLACE OF SERVICE
Enter the appropriate place of service code designating where the requested service/procedure/item will be provided/performed/dispensed.

Code	Description
1	Inpatient Hospital
2	Outpatient Hospital
3	Office
4	Home
7	Nursing Home
8	Skilled Nursing Facility
9	Ambulance

Alpha	Description
A	Independent Lab

NOTE:
Mental health services may not be provided in the recipient's home (POS 4).

Instructions for the Completion of the
Prior Authorization Request Form (PA/RF)
Page 4

ELEMENT 17 - TYPE OF SERVICE
Enter the appropriate type of service code for each service/procedure/item requested. DO NOT COMPLETE THIS ELEMENT IF REQUESTING A THERAPY (PT, OT, SPEECH) SPELL OF ILLNESS.

Numeric	Description
0	Blood
1	Medical (including: Physician's Medical Services, Home Health,
2	Surgery Independent Nurses, Audiology, PT, OT, ST, Personal
3	Consultation Care, AODA, and Day Treatment)
4	Diagnostic X-Ray - Total Charge
5	Diagnostic Lab - Total Charge
6	Radiation Therapy - Total Charge
7	Anesthesia
8	Assistant Surgery
9	Other including:
	Transportation
	*Non-MD Psych.
	Family Planning Clinic
	Rehabilitation Agency
	Nurse Midwife
	Chiropractic

* non-board operated only

Alpha	
B	Diagnostic Medical - Total
C	Ancillaries, Hospital and Nursing Home
D	Drugs
E	Accommodations, Hospital and Nursing Home
F	Free Standing Ambulatory Surgical Center
G	Dental
J	Vision Care and Cataract Lens
K	Nuclear Medicine - Total Charge
P	Purchase New DME
Q	Diagnostic X-Ray - Professional
R	DME Rental
S	Radiation Therapy - Professional
T	Nuclear Medicine - Professional
U	Diagnostic X-Ray, Medical - Technical
W	Diagnostic Medical - Professional
X	Diagnostic Lab - Professional

Instructions for the Completion of the
Prior Authorization Request Form (PA/RF)
Page 5

ELEMENT 18 - DESCRIPTION OF SERVICE
Enter a written description corresponding to the appropriate revenue, HCPCS or National Drug Code (NDC) procedure code for each service/procedure/item requested.

NOTE:
If you are requesting a therapy spell of illness, enter 'Spell of Illness' in this element.

ELEMENT 19 - QUANTITY OF SERVICE REQUESTED
Enter the quantity (sessions, number of services, etc.) requested for each service/procedure/item requested.

AODA Services (number of services)
Audiology Services (number of services)
Chiropractic (number of adjustments)
Day Treatment Services (number of services)
Dental (number of services)
Disposable Medical Supplies (number of days supply)
Drugs (number of days supply)
Durable Medical Equipment (number of services)
Hearing Aid (number of services)
Home Health (number of units)/Independent Nurses (number of units)
Services/Home Health Therapy-PT, OT, Speech (number of visits)
Hospital Transplant Services (per hospital stay)
Hospital and Nursing Home AIDS Services (number of days)
Hospital and Nursing Home Ventilator Services (number of days)
Occupational Therapy (number of services)
Occupational Therapy (spell of illness only) (enter 45)
Orthodontics (dollar amount)
Personal Care Services (number of hours)
Physical Therapy (number of services)
Physical Therapy (spell of illness only) (enter 45)
Physician Services (number of services)
Psychotherapy (HCFA 1500 billing providers only) (number of services)
Psychotherapy (UB82 billing providers only) (dollar amount)
Speech Therapy (number of services)
Speech Therapy (spell of illness only) (enter 45)
Vision (number of services)

NOTE:
If requesting a therapy spell of illness, enter '45' in this element.

Instructions for the Completion of the
Prior Authorization Request Form (PA/RF)
Page 6

ELEMENT 20 - CHARGES
Enter your usual and customary charge for each service/procedure/item requested. DO NOT COMPLETE THIS ELEMENT IF REQUESTING A THERAPY (PT, OT, SPEECH) SPELL OF ILLNESS.

> **NOTE:**
> The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Approval of a prior authorization is for the service only. Providers are reimbursed for authorized services according to Terms of Provider Reimbursement issued by the Department of Health & Social Services.

ELEMENT 21 - TOTAL CHARGE
Enter the anticipated total charge for this request. DO NOT COMPLETE THIS ELEMENT IF REQUESTING A THERAPY (PT, OT, SPEECH) SPELL OF ILLNESS.

ELEMENT 22 - BILLING CLAIM CLARIFICATION STATEMENT
'An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval date or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and policy. If the recipient is enrolled in a medical assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.'

ELEMENT 23 - DATE
Enter the month, day and year (in MM/DD/YY format) the prior authorization request form was completed and signed.

ELEMENT 24 - REQUESTING PROVIDER'S SIGNATURE
The signature of the provider requesting/performing/dispensing the service/procedure/item must appear in this element.

DO NOT ENTER ANY INFORMATION BELOW THE SIGNATURE OF THE REQUESTING PROVIDER -- THIS SPACE IS RESERVED FOR THE WISCONSIN MEDICAL ASSISTANCE PROGRAM CONSULTANT(S) AND ANALYST(S).

MAIL TO
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM

PA/RF (DO NOT WRITE IN THIS SPACE)

ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE: 111

2 RECIPIENT'S MEDICAL ASSISTANCE I.D. NUMBER: 1234567890

3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient, Im A.

4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow, Anytown, WI 53725

5 DATE OF BIRTH: MM/DD/YY

6 SEX: M [ ] F [X]

7 BILLING PROVIDER TELEPHONE NO.: (XXX) XXX-XXXX

8 BILLING PROVIDE NAME, ADDRESS, ZIP CODE:
I. M. Provider
1 W. Wilson
Anytown, WI 53725

9. BILING PROVIDER NO.: 12345678

10. DX: PRIMARY: 436 - CVA

11. DX: SECONDARY: 344.0 - Quadriplegia

12. START DATE OF SOI: N/A

13. FIRST DATE RX: N/A

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
97200		8	9	Physical Therapy	3	XX.XX
					TOTAL CHARGE	21 XX.XX

An approved authorization does not guarantee payment. Reimbusement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

22 MM/DD/YY — DATE

23 I. M. Provider — REQUESTING PROVIDER SIGNATURE

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

[ ] APPROVED

GRANT DATE | EXPIRATION DATE | PRODEDURE(S) AUTHORIZED | QUANTITY AUTHORIZED

[ ] MODIFIED — REASON:

[ ] DENIED — REASON:

[ ] RETURN — REASON:

DATE

CONSULTANT/ANALYST SIGNATURE

MAPB-087-016-0
Date: 9/1/87

Attachment 6b

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM

PA/RF (DO NOT WRITE IN THIS SPACE)

ICN #
A.T. #
P.A. # 1234567

1. PROCESSING TYPE: 112

2. RECIPIENT'S MEDICAL ASSISTANCE I.D. NUMBER: 1234567890

3. RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient, Im A.

4. RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): I.M. Nursing Home, 609 Willow, Anytown, WI 53725

5. DATE OF BIRTH: MM/DD/YY

6. SEX: M [X] F [ ]

7. BILLING PROVIDER TELEPHONE NO: (XXX) XXX-XXXX

8. BILLING PROVIDE NAME, ADDRESS, ZIP CODE: I. M. Provider, 1 W. Williams, Anytown, WI 53725

9. BILING PROVIDER NO: 12345678

10. DX PRIMARY: 720 Rheumatoid Spondylitis

11. DX SECONDARY: 345.1 Epilepsy

12. START DATE OF SOI: N/A

13. FIRST DATE Rx: N/A

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
W9523		8	9	Range of Motion, Strengthening	1	XX.XX
W9529		8	9	Activities of Daily Living	1	XX.XX
					TOTAL CHARGE	21 XX.XX

An approved authorization does not guarantee payment. Reimbusement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

22 MM/DD/YY (DATE)

23 I. M. PROVIDER I. M. Provider (REQUESTING PROVIDER SIGNATURE)

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

[ ] APPROVED

GRANT DATE

EXPIRATION DATE

PRODEDURE(S) AUTHORIZED QUANTITY AUTHORIZED

[ ] MODIFIED — REASON:

[ ] DENIED — REASON

[ ] RETURN — REASON:

DATE

CONSULTANT/ANALYST SIGNATURE

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM

PA/RF (DO NOT WRITE IN THIS SPACE)

ICN #
A.T. #
P.A. # 1234567

1. PROCESSING TYPE: 113

2 RECIPIENT'S MEDICAL ASSISTANCE I.D. NUMBER: 1234567890

3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient, Im A.

4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): I. M. Nursing Home, 609 Willow, Anytown, WI 53725

5 DATE OF BIRTH: MM/DD/YY

6. SEX: M ☐ F ☒

7. BILLING PROVIDER TELEPHONE NO.: (XXX) XXX-XXXX

8 BILLING PROVIDE NAME, ADDRESS, ZIP CODE:
I. M. Provider
1 W. Williams
Anytown, WI 53725

9. BILING PROVIDER NO: 12345678

10. DX. PRIMARY: 436 - Cerebral Palsy

11. DX. SECONDARY: 783.4 - Developmental Delay

12. START DATE OF SOI: N/A

13. FIRST DATE RX: N/A

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
92507		8	9	Speech Therapy	2	XX.XX
				TOTAL CHARGE		21 XX.XX

An approved authorization does not guarantee payment. Reimbusement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

22 MM/DD/YY — DATE

23 I. M. Provider — REQUESTING PROVIDER SIGNATURE

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

☐ APPROVED — GRANT DATE — EXPIRATION DATE — PRODEDURE(S) AUTHORIZED — QUANTITY AUTHORIZED

☐ MODIFIED — REASON:

☐ DENIED — REASON:

☐ RETURN — REASON:

DATE — CONSULTANT/ANALYST SIGNATURE

INSTRUCTIONS FOR THE COMPLETION OF THE PRIOR AUTHORIZATION THERAPY ATTACHMENT (PA/TA) (Physical, Occupational, Speech Therapy)

Do not use this attachment to request a spell of illness, use the Prior Authorization Spell of Illness Attachment (PA/SOIA).

The timely determination of authorization is significantly enhanced by the completeness and quality of the documentation submitted by providers when requesting prior authorization to extend treatment beyond forty-five treatment days for the same spell of illness. Carefully complete this attachment form, attach it to the Prior Authorization Request Form (PA/RF) and submit to the following address:

E.D.S. Federal Corporation
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

Questions regarding completion of the Prior Authorization Request Form (PA/RF) and/or the Prior Authorization Therapy Attachment (PA/TA) or the Prior Authorization Spell of Illness Attachment (PA/SOIA) may be addressed to EDS' Telephone/Written Correspondence Unit.

RECIPIENT INFORMATION:

ELEMENT 1 - RECIPIENT'S LAST NAME
Enter the recipient's last name exactly as it appears on the recipient's medical assistance identification card.

ELEMENT 2 - RECIPIENT'S FIRST NAME
Enter the recipient's first name exactly as it appears on the recipient's medical assistance identification card.

ELEMENT 3 - RECIPIENT'S MIDDLE INITIAL
Enter the recipient's middle initial exactly as it appears on the recipient's medical assistance identification card.

ELEMENT 4 - RECIPIENT'S MEDICAL ASSISTANCE NUMBER
Enter the recipient's ten digit medical assistance number exactly as it appears on the recipient's medical assistance identification card.

ELEMENT 5 - RECIPIENT'S AGE
Enter the age of the recipient in numerical form (i.e., 45, 60, 21, etc.).

Instructions for the Completion of the Prior
Authorization Therapy Attachment (PA/TA)
(Physical, Occupational, Speech Therapy)
Page 2

PROVIDER INFORMATION:

ELEMENT 6 - THERAPIST'S NAME AND CREDENTIALS
Enter the name and credentials of the primary therapist who would be responsible for and participate in therapy services for the recipient. If the performing provider will be a therapy assistant, enter the name of the supervising therapist.

ELEMENT 7 - THERAPIST'S MEDICAL ASSISTANCE PROVIDER NUMBER
Enter the eight digit medical assistance provider number of the therapist who would provide the authorized service (performing provider). If the performing provider will be a therapy assistant, enter the medical assistance provider number of the supervising therapist.

ELEMENT 8 - THERAPIST'S TELEPHONE NUMBER
Enter the telephone number, including area code, of the therapist who would provide the authorized service (performing provider). If the performing provider would be a therapy assistant, enter the telephone number of the supervising therapist.

ELEMENT 9 - REFERRING/PRESCRIBING PHYSICIAN'S NAME
Enter the name of the physician referring/prescribing evaluation/ treatment.

* *

The remaining portions of this attachment are to be used to document the justification for the requested service.

1. Complete elements A through J.

2. Element E - Provide a brief past history based on available information.

   Element I - Provide the recipient's perceived potential to meet therapy goals.

3. Read the Prior Authorization Statement before dating and signing the attachment.

Instructions for the Completion of the Prior
Authorization Therapy Attachment (PA/TA)
(Physical, Occupational, Speech Therapy)
Page 3

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4. The attachment must be signed and dated by the primary therapist who will be responsible for and participate in therapy services for the recipient. If the performing provider will be a therapy assistant, the attachment must be signed by the supervising therapist.

   The form must be signed and dated by the prescribing physician. **NOTE:** A copy of the signed physician's order sheet is acceptable in lieu of the physician's signature.

ATTACHMENT 7a

MAPB-087-016-D
Date: 9/1/87

Mail To:

E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/TA

THERAPY ATTACHMENT

(Physical- Occupational-Speech Therapy)

1. Complete this form
2. Attach to PA/RF (Prior Authorization Request Form)
3. Mail to EDS

RECIPIENT INFORMATION

① LAST NAME	② FIRST NAME	③ MIDDLE INITIAL	④ MEDICAL ASSISTANCE ID NUMBER	⑤ AGE
RECIPIENT	IM	A	123456789Ø	29

PROVIDER INFORMATION

⑥ THERAPIST'S NAME AND CREDENTIALS	⑦ THERAPIST'S MEDICAL ASSISTANCE PROVIDER NUMBER	⑧ THERAPIST'S TELEPHONE NUMBER
I.M. PERFORMING, PT.	12345678	(XXX) XXX - XXXX

⑨ REFERRING/PRESCRIBING PHYSICIAN'S NAME: I.M. REFERRING/PRESCRIBING

A. Requesting: ☒ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy

B. Total time per day requested: 30 min.
Total Sessions per week requested: 3
Total number of weeks requested: 26

C. Provide a description of the recipient's diagnosis and problems and date of onset.

R CVA 12-27-86
HYSTERECTOMY 2° TO ADENOCARCINOMA - 1986
ADULT ONSET DIABETES - SEVERAL YRS DURATION
CHF-SEVERAL YEARS DURATION

D. BRIEF PERTINENT HISTORY:

PT WAS ADMITTED 1-12-87 AFTER HOSPITALIZATION FOR ACUTE CVA 12-27-86. HOSPITALIZED FROM 3-6-87 TO 3-12-87 FOR PNEUMONIA. HAS BEEN MEDICALLY STABLE AND ALERT SINCE RETURN ON 3-12-87.

E. Therapy History

	Location	Date	Problem Treated
PT	HOSPITAL	1-2-87 to 1-11-87	CVA
	NURSING HOME	1-13-87 to 3-4-87	CVA
		3-14-87 to PRESENT	

OT

N/A

SP

N/A

F. Evaluations: (Indicate Dates/Tests Used/Results) (Provide Date of Initial Evaluation).

	1-13-87	3-14-87
ORIENTATION	A & O X3	A & O X 3
ROM	WFL EXCEPT (L) SHLDR FLEX 140% ABD 140% ER 45% (L) KNEE EXT -10%	WFL EXCEPT (L) SHLDR FLEX 110% ABD 110% ER 45% (L) KNEE EXT -15% (L) ANKLE DORSI -10%
STRENGTH	(R) EXTREMITIES IN G RANGE (L) UE FLACCID (L) LE HIP & KNEE P RANGE ANDKLE 0	(R) U & L E F+ TO G- (L) UE NON-FUNC C MODERATE FLEXION SPACTICITY PRESENT (L) LE HIP & KNEE F ANKLE TRACE
TRANSFERS	STNDG PIVOT REQUIRES MAX OF 2	SPT MOD OF 1
ELEVATIONS	SUPINE ↔ SIT MAX OF 1 SIT ↔ STAND MAX OF 2	SUPINE ↔ SIT MIN OF 1 SIT ↔ STAND MOD OF 1
AMB	NON-AMB	IN 11 BARS OF 10'x2 REQUIRES MAX OF 1 ABLE TO ADVANCE L LE INDEP 70% of TIME
SITTING BALANCE	UNSUPPORTED REQUIRES MAX OF 1	UNSUPPORTED INDEP X 60 SEC IF UNCHALLENGED

G. Describe progress in measurable/functional terms since treatment was initiated or last authorized:

6-18-87

ORIENTATION 0

ROM MAINTAINED C IN (L) KNEE EXT TO -5 & (L) ANKLE DORSIFLEX TO NEUTRAL

STRENGTH (R) U & LE G TO G+ (L) UE NON-FUNC (L) LE HIP & KNEE F+ TO G- ANKLE P RANGE AFO OBTAINED 5-15-87 TO ASSIST IN TRANSFER/GAIT

TRANSFERS STNDY PIVOT C GUARDED TO MIN OF 1 IN PT & ON UNIT

ELEVATIONS SUPINE ↔ SIT ↔ STAND C GUARDED TO MIN OF 1

AMB USES HEMIWALKER C MIN ASSIST OF 1 FOR 10' x2. AMB x1/DAY ON NURSING UNIT FOR 40'.

SITTING BALANCE ABLE TO ACCEPT MODERATE CHALLENGES AND MAINTAIN BALANCE INDEP

H. Plan of Care (Indicate specific measurable goals and procedures to meet those goals).

	GOALS STG	PROCEDURES
1.	AMB C HEMIWALKER C STANDBY ASSIST OF 1 120' x 2	GAIT TRAINING THERAPUTIC EXERCISE
2.	INDEP ELEVATIONS	MAT PROGRAM
3.	SPT C STANDBY ASSIST OF 1	FOLLOW THROUGH OF PROGRAM C NURSING
	LTG INDEP IN ALL MOBILITY RETURN TO INDEP LIVING	

I. Rehabilitation Potential:

VERY GOOD POTENTIAL TO MEET ABOVE GOALS. PT HAS PROGRESS STEADILY C SHORT PERIOD OF DECLINE IN MARCH ONLY.

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

J. L. M. Prescribing
Signature of Prescribing Physician
(A copy of the Physician's order sheet is acceptable)

MM/DD/YY
Date

L. M. Performing
Signature of Therapist Providing Treatment

MM/DD/YY
Date

Attachment 7b

MAPB-087-016-D
Date: 9/1/87

Mail To:

E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/TA

THERAPY ATTACHMENT

(Physical- Occupational-Speech Therapy)

1. Complete this form
2. Attach to PA/RF (Prior Authorization Request Form)
3. Mail to EDS

RECIPIENT INFORMATION

(1) LAST NAME	(2) FIRST NAME	(3) MIDDLE INITIAL	(4) MEDICAL ASSISTANCE ID NUMBER	(5) AGE
RECIPIENT	IM	A	1234567890	19

PROVIDER INFORMATION

(6) THERAPIST'S NAME AND CREDENTIALS	(7) THERAPIST'S MEDICAL ASSISTANCE PROVIDER NUMBER	(8) THERAPIST'S TELEPHONE NUMBER
I.M. PERFORMING, O.T.R.	12345678	(XXX) XXX - XXXX

(9) REFERRING/PRESCRIBING PHYSICIAN'S NAME: I.M. REFERRING/PRESCRIBING

A. Requesting: ☐ Physical Therapy ☒ Occupational Therapy ☐ Speech Therapy

B. Total time per day requested: 60 minutes
Total Sessions per week requested: 3 for each procedure requested.
Total number of weeks requested: 16

C. Provide a description of the recipient's diagnosis and problems and date of onset.

PRIMARY DIAGNOSIS	ICD9 CODE	DATE OF ONSET
Rheumatoid Spondylitis	720	Age 16

SECONDARY DIAGNOSIS	ICD9 CODE	DATE OF ONSET
1. Epilepsy (Major Motor)	345.1	Age 4

D. Brief Pertinent History:

Client lived at home with family prior to last nursing home admission. Client has completed high school and is a part-time student at XYZ University, in Data Processing.

E. Therapy History

		Location	Date	Problem Treated
PT	ABC Hospital	Anytown, WI	1985	Spinal Involvement of Rheumatoid Spondylitis
	XYZ Nursing Home	Anytown, WI	7/1 - 8/15/86	Gait, Balance and Dependence in ADL
OT	ABC Hospital	Anytown, WI	6/1986	Balance and Transfers
	XYZ Nursing Home	Anytown, WI	7/1 - 8/15/86	Dependence in self care.
SP	N/A			

F. Evaluations: (Indicate Dates/Tests Used/Results) (Provide Date of Initial Evaluation).

1) 5/18/87 Comprehensive Functional Evaluation upon admission to nursing home. ADL - dependence in all areas of self care. Motor Skills - see attached ROM, MMT, and Coordination Tests. Perceptual Skills - assessment attached.

2) 6/22/87 ADL - can perform oral facial hygiene, dress upper extremity with physical assist. Motor Skills - refer to attached chart with ROM, MMT, and Coordination.

3) 7/27/87 ADL - dress upper and lower extremities, but needs assistance with buttons and zippers. Homemaking Eval. - see attached. Motor Skills - refer to attached chart with ROM, MMT, and Coordination.

G. Describe progress in measurable/functional terms since treatment was initiated or last authorized:

1) Client is now able to button 1" buttons, but lacks finger dexterity to accomplish smaller sizes.

2) Client can perform all other areas of personal care including dressing, hygiene, toileting, bathing.

3) Range of motion has improved significantly in most areas - see attached charts 5/18; 6/22; and 7/27/87.

H. Plan of Care (Indicate specific measurable goals and procedures to meet those goals).

1) Client will manage 1/2" and 3/4" buttons and zippers.

2) Client will increase and maintain ROM to functional limits for his disability A home program of exercises will also be initiated.

3) Client will prepare all meals independently with adaptations. Laundry and light cleaning skills will also be initiated.

I. Rehabilitation Potential:

Expect discharge to adapted apartment by December 15, 1987.

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

J. I. M. Prescribing
Signature of Prescribing Physician
(A copy of the Physician's order sheet is acceptable)

MM/DD/YY
Date

I. M. Performing
Signature of Therapist Providing Treatment

MM/DD/YY
Date

ATTACHMENT 7c

Mail To:

E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/TA

THERAPY ATTACHMENT

(Physical- Occupational-Speech Therapy)

1. Complete this form
2. Attach to PA/RF (Prior Authorization Request Form)
3. Mail to EDS

RECIPIENT INFORMATION

① LAST NAME	② FIRST NAME	③ MIDDLE INITIAL	④ MEDICAL ASSISTANCE ID NUMBER	⑤ AGE
RECIPIENT	IM	A	1234567890	64

PROVIDER INFORMATION

⑥ THERAPIST'S NAME AND CREDENTIALS	⑦ THERAPIST'S MEDICAL ASSISTANCE PROVIDER NUMBER	⑧ THERAPIST'S TELEPHONE NUMBER
I.M. PERFORMING, M.S.	12345678	(XXX) XXX - XXXX

⑨ I.M. REFERRING/PRESCRIBING
REFERRING/PRESCRIBING PHYSICIAN'S NAME

A. Requesting: ☐ Physical Therapy ☐ Occupational Therapy ☑ Speech Therapy

B. Total time per day requested 30 min.
Total Sessions per week requested 2
Total number of weeks requested 26

C. Provide a description of the recipient's diagnosis and problems and date of onset.

CEREBRAL PALSY SINCE BIRTH. SUFFERS FROM VASCULAR HYPERTENSION, DEGENERATIVE JOINT DISEASE, DIVERTICULOSIS OF COLON, SUBACUTE CHOLECYSTITIS AND CHOLEITHIASIS.

D. BRIEF PERTINENT HISTORY:

64 YEAR OLD FEMALE WITH CEREBRAL PALSY. SHE HAS BEEN A RESIDENT OF I.M. PROVIDER NURSING HOME SINCE 11/82. SHE IS INVOLVED IN MANY ACTIVITIES IN THE NURSING HOME AND ATTENDS SCHOOL 3 DAYS A WEEK WHERE THEY CALL HER A "LEADER". SHE IS MOTIVATED AND STRIVES TO BE THE BEST SHE CAN.

Location	Date	Problem Treated

E. Therapy History

PT

N.A.

OT

N.A.

SP

RECEIVED SPEECH THERAPY SINCE 1/86. P.T. SINCE 2/86, also at I.M. PROVIDER NURSING HOME.

F. Evaluations: (Indicate Dates/Tests Used/Results) (Provide Date of Initial Evaluation).

NO FORMAL EVALUATIONS FOUND IN HER CHART PRIOR TO 11/86.

2/87 - ORAL MECHANISM EXAMINATION REVEALED REDUCED TONGUE, LIP AND JAW MOVEMENTS. NORMAL PHONATION FOR THIS POPULATION IS 16.0 SECONDS (CAMPBELL AND BLESS 1980). DIADOCKOKINETIC RATES (AMR AND SMK) WERE SLOW, DYSRYTHMIC UNEVEN IN LOUDNESS AND COUNTABLE. THIS REDUCED HER INTELLIGIBILITY SIGNIFICANTLY.

G. Describe progress in measurable/functional terms since treatment was initiated or last authorized:

SHE WAS GIVEN A COMMUNICATION BOOKLET TO USE IN NOV. 1986. SHE REPORTS THAT HER USE OF THE BOOKLET IS MINIMAL DUE TO THE FACT THAT SHE DOESN'T LIKE IT. THERAPY FOCUSED ON ARTICULATION ONLY PREVIOUS TO 11/86.

SINCE 2/87 THERAPY HAS FOCUSED ON ORAL EXERCISES TO INCREASE ORAL MUSCULATIVE STRENGTH AND CONTROL. HER LIP AND TONGUE MOVEMENTS HAVE INCREASED SIGNIFICANTLY IN THAT SHE IS NOW 70% INTELLIGIBLE ON THE PHONEMES.

Date: 9/1/87

H. Plan of Care (Indicate specific measurable goals and procedures to meet those goals).

1) IMPROVE ORAL MUSCULATURE STRENGTH AND CONTROL.

2) IMPROVE COMPENSATED INTELLIGIBILITY TO 80%.

3) INCREASE USE OF COMMUNICATION BOOKLET TO STAFF AND SCHOOL TEACHERS FOR BETTER COMMUNICATION.

I. Rehabilitation Potential:

GOOD - SHE IS MOTIVATED TO IMPROVE HER SPEECH.

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

J. L.M. Prescribing
Signature of Prescribing Physician
(A copy of the Physician's order sheet is acceptable)

MM/DD/YY
Date

L.M. Performing
Signature of Therapist Providing Treatment

MM/DD/YY
Date

INSTRUCTIONS FOR THE COMPLETION OF THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF) FOR A SPELL OF ILLNESS (Physical, Occupational, Speech Therapy)

ELEMENT 1 - PROCESS TYPE
Enter the appropriate three digit process type in this element. Spell of illness requests will be returned without adjudication if no process type is indicated.

114 - Physical Therapy Spell of Illness
115 - Occupational Therapy Spell of Illness
116 - Speech Therapy Spell of Illness

ELEMENT 2 - RECIPIENT'S MEDICAL ASSISTANCE NUMBER
Enter the ten digit medical assistance recipient number exactly as it appears on the recipient's medical assistance identification card.

ELEMENT 3 - RECIPIENT'S NAME
Enter the recipient's last name, followed by first name and middle initial, exactly as it appears on the recipient's medical assistance identification card.

ELEMENT 4 - RECIPIENT'S ADDRESS
Enter the address of the recipient's place of residence; the street, city, state and zip code must be included. If the recipient is a resident of a nursing home or other facility, also include the name of the nursing home or facility.

ELEMENT 5 - RECIPIENT'S DATE OF BIRTH
Enter the recipient's date of birth in MM/DD/YY format (i.e., June 8, 1941 would be 06/08/41) exactly as it appears on the recipient's medical assistance identification card.

ELEMENT 6 - RECIPIENT'S SEX
Enter an 'X' to specify male or female.

ELEMENT 7 - BILLING PROVIDER'S NAME, ADDRESS AND ZIP CODE
Enter the name and complete address (street, city, state and zip code) of the billing provider. No other information should be entered in this element as it also serves as a return mailing label.

ELEMENT 8 - BILLING PROVIDER'S TELEPHONE NUMBER
Enter the telephone number, including the area code, of the office, clinic, facility or place of business of the billing provider.

ELEMENT 9 - BILLING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER
Enter the eight digit medical assistance provider number of the billing provider.

Instructions for the Completion of the
Prior Authorization Request Form (PA/RF)
for a Spell of Illness
(Physical, Occupational, Speech Therapy)
Page 2

ELEMENT 10 - RECIPIENT'S PRIMARY DIAGNOSIS
Enter the appropriate International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis code and description most relevant to the spell of illness.

ELEMENT 11 - RECIPIENT'S SECONDARY DIAGNOSIS
Enter the appropriate International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis code and description additionally descriptive of the recipient's condition.

ELEMENT 12 - START DATE OF SPELL OF ILLNESS
Enter the date of onset for the new spell of illness in MM/DD/YY format (i.e., March 1, 1988 would be 03/01/88).

ELEMENT 13 - FIRST DATE OF TREATMENT (SPELL OF ILLNESS)
Enter the date of the first treatment or evaluation for the new spell of illness in MM/DD/YY format (i.e., March 9, 1988 would be 03/09/88).

ELEMENT 14 - PROCEDURE CODE(S)
(leave this element blank)

ELEMENT 15 - MODIFIERS
(leave this element blank)

ELEMENT 16 - PLACE OF SERVICE
Enter the appropriate place of service code (3 - Office, 4 - Home, 7- Nursing Home, 8 - Skilled Nursing Facility).

ELEMENT 17 - TYPE OF SERVICE
(leave this element blank)

ELEMENT 18 - DESCRIPTION OF SERVICE
Enter the description 'Spell of Illness' in this element.

ELEMENT 19 - QUANTITY OF SERVICE REQUESTED
Enter '45' in this element, signifying forty-five treatment days.

ELEMENT 20 - CHARGES
(leave this element blank)

ELEMENT 21 - TOTAL CHARGES
(leave this element blank)

Instructions for the Completion of the
Prior Authorization Request Form (PA/RF)
for a Spell of Illness
(Physical, Occupational, Speech Therapy)
Page 3

ELEMENT 22 - BILLING CLAIM PAYMENT CLARIFICATION STATEMENT
Please read the 'Billing Claim Payment Clarification Statement' printed on the request before dating and signing the prior authorization request form.

> 'An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided, and the completeness of the claim information. Payment will not be made for services initiated prior to approval date or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program (WMAP) payment methodology and policy. If the recipient is enrolled in a medical assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.'

ELEMENT 23 - DATE
Enter the month, day and year the request form was completed and signed.

ELEMENT 24 - REQUESTING PROVIDER'S SIGNATURE
The signature of the provider (therapist) requesting the spell of illness must appear in this element.

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM

PA/RF (DO NOT WRITE IN THIS SPACE)

ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE: 114

2 RECIPIENT'S MEDICAL ASSISTANCE I.D. NUMBER: 1234567890

3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient, Jr. A.

4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE):
I. M. Nursing Home
609 Willow
Anytown, WI 53725

5 DATE OF BIRTH: MM/DD/YY

6 SEX: M ☐ F ☒

7 BILLING PROVIDER TELEPHONE NO.: (XXX) XXX-XXXX

8 BILLING PROVIDE NAME, ADDRESS, ZIP CODE:
I. M. Provider
1 W. Wilson
Anytown, WI 53725

9 BILING PROVIDER NO.: 1234567

10 DX. PRIMARY: 436 - CVA

11 DX: SECONDARY: 344.0 - Quadriplegia

12 START DATE OF SOI: MM/DD/YY

13 FIRST DATE Rx: MM/DD/YY

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
		8		Physical Therapy Spell of Illness	45	
					TOTAL CHARGE	21

An approved authorization does not guarantee payment. Reimbusement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

22. MM/DD/YY (DATE)

23. I. M. Provider (REQUESTING PROVIDER SIGNATURE)

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

☐ APPROVED

GRANT DATE _____ EXPIRATION DATE _____ PRODEDURE(S) AUTHORIZED QUANTITY AUTHORIZED

☐ MODIFIED — REASON:

☐ DENIED — REASON:

☐ RETURN — REASON:

DATE _____ CONSULTANT/ANALYST SIGNATURE _____

MAIL TO
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM

PA/RF (DO NOT WRITE IN THIS SPACE)

ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE: 115

2 RECIPIENT'S MEDICAL ASSISTANCE I.D. NUMBER: 1234567890

3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): RECIPIENT, Im A.

4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE):
I.M. Nursing Home
609 Willow
Anytown, WI 53725

5 DATE OF BIRTH: MM/DD/YY

6 SEX: M ☐ F ☒

7 BILLING PROVIDER TELEPHONE NO: (XXX) XXX-XXXX

8 BILLING PROVIDE NAME, ADDRESS, ZIP CODE:
I. M. PROVIDER
1 W. Williams
Anytown, WI 53725

9 BILING PROVIDER NO: 12345678

10 DX PRIMARY: 720 Rheumatoid Spondylitis

11 DX SECONDARY: 345.1 Epilepsy

12 START DATE OF SOI: MM/DD/YY

13 FIRST DATE Rx: MM/DD/YY

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
		8		OT Spell of Illness	45	
					TOTAL CHARGE	21

An approved authorization does not guarantee payment. Reimbusement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

22 MM/DD/YY
DATE

23 I. M. Provider I. M. Provider
REQUESTING PROVIDER SIGNATURE

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

☐ APPROVED

GRANT DATE

EXPIRATION DATE

PRODEDURE(S) AUTHORIZED QUANTITY AUTHORIZED

☐ MODIFIED — REASON:

☐ DENIED — REASON:

☐ RETURN — REASON:

DATE

CONSULTANT/ANALYST SIGNATURE

ATTACHMENT 8c

MAPB-087-016-D
Date: 9/1/87

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM

PA/RF (DO NOT WRITE IN THIS SPACE)

ICN #
A.T. #
P.A. # 1234567

1. PROCESSING TYPE: 116

2. RECIPIENT'S MEDICAL ASSISTANCE I.D. NUMBER: 1234567890

3. RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient, Im A.

4. RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE):
I. M. Nursing Home
609 Willow
Anytown, WI 53725

5. DATE OF BIRTH: 02/06/00

6. SEX: M ☐ F ☒

7. BILLING PROVIDER TELEPHONE NO.: (XXX) XXX-XXXX

8. BILLING PROVIDE NAME, ADDRESS, ZIP CODE:
I. M. Provider
1 W. Williams
Anytown, WI 53725

9. BILING PROVIDER NO.: 12345678

10. DX: PRIMARY: 343.9 - Cerebral Palsy

11. DX: SECONDARY: 783.4 - Developmental Delay

12. START DATE OF SOI: MM/DD/YY

13. FIRST DATE RX: MM/DD/YY

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
		8		Speech Spell of Illness	45	
					TOTAL CHARGE	21

An approved authorization does not guarantee payment. Reimbusement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

22. MM/DD/YY — DATE

23. I. M. Provider — REQUESTING PROVIDER SIGNATURE

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

☐ APPROVED — GRANT DATE — EXPIRATION DATE — PRODEDURE(S) AUTHORIZED — QUANTITY AUTHORIZED

☐ MODIFIED — REASON:

☐ DENIED — REASON:

☐ RETURN — REASON:

DATE

CONSULTANT/ANALYST SIGNATURE

INSTRUCTIONS FOR THE COMPLETION OF THE PRIOR AUTHORIZATION SPELL OF ILLNESS ATTACHMENT (PA/SOIA) (Physical, Occupational, Speech Therapy)

Do not use this attachment to request prior authorization to extend treatment beyond forty-five treatment days for the same spell of illness, use the Prior Authorization Therapy Attachment (PA/TA).

The timely determination of authorization is significantly enhanced by the completeness and quality of the documentation submitted by providers when requesting prior authorization for a spell of illness. Carefully complete this attachment form, attach it to the Prior Authorization Request Form (PA/RF) and submit to the following address:

E.D.S. Federal Corporation
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

Questions regarding completion of the Prior Authorization Request Form (PA/RF) and/or the Prior Authorization Spell of Illness Attachment (PA/SOIA) may be addressed to EDS' Telephone/Written Correspondence Unit.

RECIPIENT INFORMATION:

ELEMENT 1 - RECIPIENT'S LAST NAME
Enter the recipient's last name exactly as it appears on the recipient's medical assistance identification card.

ELEMENT 2 - RECIPIENT'S FIRST NAME
Enter the recipient's first name exactly as it appears on the recipient's medical assistance identification card.

ELEMENT 3 - RECIPIENT'S MIDDLE INITIAL
Enter the recipient's middle initial exactly as it appears on the recipient's medical assistance identification card.

ELEMENT 4 - RECIPIENT'S MEDICAL ASSISTANCE NUMBER
Enter the recipient's ten digit medical assistance number exactly as it appears on the recipient's medical assistance identification card.

ELEMENT 5 - RECIPIENT'S AGE
Enter the age of the recipient in numerical form (i.e., 45, 60, 21, etc.).

Instructions for the Completion of the
Prior Authorization Spell of Illness
Attachment (PA/SOIA)
(Physical, Occupational, Speech Therapy)
Page 2

PROVIDER INFORMATION:

ELEMENT 6 - THERAPIST'S NAME AND CREDENTIALS
Enter the name and credentials of the primary therapist who would be responsible for and participate in therapy services for the recipient. If the performing provider will be a therapy assistant, enter his/her name and credentials, also enter the name of the supervising therapist.

ELEMENT 7 - THERAPIST'S MEDICAL ASSISTANCE PROVIDER NUMBER
Enter the eight digit medical assistance provider number of the therapist who would provide the authorized service (performing provider). If the performing provider will be a therapy assistant, enter his/her medical assistance provider number, also enter the medical assistance provider number of the supervising therapist.

ELEMENT 8 - THERAPIST'S TELEPHONE NUMBER
Enter the telephone number, including area code, of the therapist who would provide the authorized service (performing provider). If the performing provider would be a therapy assistant, enter his/her telephone number and the telephone number of the supervising therapist.

ELEMENT 9 - REFERRING/PRESCRIBING PHYSICIAN'S NAME
Enter the name of the physician referring/prescribing evaluation/ treatment.

PART A
Enter an 'X' in the appropriate box to indicate a physical, occupational or speech therapy spell of illness request.

PART B
Enter a description of the recipient's diagnosis and problems. Indicate what functional regression has occurred and what the potential to reachieve the previous skill is.

PART C
Attach a copy of the recipient's Therapy Plan of Care, including a current dated evaluation to the Spell of Illness Attachment before submitting the spell of illness request.

Instructions for the Completion of the
Prior Authorization Spell of Illness
Attachment (PA/SOIA)
(Physical, Occupational, Speech Therapy)
Page 3

PART D
Enter the anticipated end date of the spell of illness in the space provided.

PART E
Attach the physician's dated signature on either the Therapy Plan of Care or copy of physician's order sheet to this attachment.

Read the Prior Authorization Statement before dating and signing the Attachment.

PART F
The signature of the prescribing physician and the date must appear in the space provided. (A signed copy of the Physician's order sheet is acceptable.)

PART G
The dated signature of the therapist providing evaluation/treatment must appear in the space provided.

Attachment 9a

MAPB-087-016-D
Date: 9/1/87

Mail To:
E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/SOIA

PRIOR AUTHORIZATION SPELL OF ILLNESS ATTACHMENT

(Physical, Occupational, Speech Therapy)

1. Complete this form
2. Attach to PA/RF (Prior Authorization Request Form)
3. Mail to EDS

RECIPIENT INFORMATION

(1) LAST NAME	(2) FIRST NAME	(3) MIDDLE INITIAL	(4) MEDICAL ASSISTANCE ID NUMBER	(5) AGE
RECIPIENT	IM	A	1234567890	29

PROVIDER INFORMATION

(6) THERAPIST'S NAME AND CREDENTIALS	(7) THERAPIST'S MEDICAL ASSISTANCE PROVIDER NUMBER	(8) THERAPIST'S TELEPHONE NUMBER
I.M. PERFORMING, P.T.	87654321	(XXX) XXX - XXXX

(9) REFERRING/PRESCRIBING PHYSICIAN'S NAME: I.M. REFERRING

A. ☒ Physical Therapy SOI ☐ Occupational Therapy SOI ☐ Speech Therapy SOI

B. Provide a description of the recipient's diagnosis and problems.
Indicate the functional regression which has occurred and the potential to reachieve the previous skill.

PT FX'D PELVIS ON 6-18-87. HAD BEEN AMB C CANE C GUARDED TO MIN ASSIST C 1 ON THE UNIT. WAS TRANSFERRING C STANDBY ASSIST ONLY. NO %PAIN. THERAPY INITIATED 6-25-87. PT REQUIRES MAX ASSIST OF 1 C WALKER TO AMB. TRANSFERS REQUIRE MAX OF 1. % PAIN IS CONSTANT C ANY MOVEMENT. EXPECT PT TO RETURN TO PREVIOUS AMB/TRANSFER STATUS AND TO BE MAINTAINED BY RESTORATIVE NURSING.

C. Attach a copy of the recipient's Therapy Plan of Care, including a current evaluation.

D. What is the anticipated end date of the spell of illness. MM/DD/YY

E. Supply the physician's dated signature on either the Therapy Plan of Care or the Physician's Order Sheet.

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

F. I. M. Prescribing — Signature of Prescribing Physician (A copy of the Physician's Order Sheet is acceptable) — MM/DD/YY Date

G. I. M. Performing — Signature of Therapist Providing Treatment / EVALUATION — MM/DD/YY Date

Mail To:

E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/SOIA

PRIOR AUTHORIZATION SPELL OF ILLNESS ATTACHMENT

(Physical, Occupational, Speech Therapy)

1. Complete this form
2. Attach to PA/RF (Prior Authorization Request Form)
3. Mail to EDS

RECIPIENT INFORMATION

(1) LAST NAME	(2) FIRST NAME	(3) MIDDLE INITIAL	(4) MEDICAL ASSISTANCE ID NUMBER	(5) AGE
RECIPIENT	IM	A	1234567890	19

PROVIDER INFORMATION

(6) THERAPIST'S NAME AND CREDENTIALS	(7) THERAPIST'S MEDICAL ASSISTANCE PROVIDER NUMBER	(8) THERAPIST'S TELEPHONE NUMBER
I.M. PERFORMING, O.T.R.	87654321	(XXX) XXX - XXXX

(9) REFERRING/PRESCRIBING PHYSICIAN'S NAME: I.M. REFERRING

A. ☐ Physical Therapy SOI ☒ Occupational Therapy SOI ☐ Speech Therapy SOI

B. Provide a description of the recipient's diagnosis and problems.
Indicate the functional regression which has occurred and the potential to reachieve the previous skill.

Client received the diagnosis of Rheumatoid Spondylitis at age 16. His condition has been progressive with involvement of both upper extremities at this time. Discharge from nursing home to his own adapted apartment with minimal help from his family is planned once his condition stabilizes. A program of range of motion, gentle stretch, gradual strengthening and activities of daily living for personal needs and adapted homemaking are possible with this intelligent, well motivated young man.

C. Attach a copy of the recipient's Therapy Plan of Care, including a current evaluation.

D. What is the anticipated end date of the spell of illness. MM/DD/YY

E. Supply the physician's dated signature on either the Therapy Plan of Care or the Physician's Order Sheet.

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

F. I. M. Prescribing — Signature of Prescribing Physician (A copy of the Physician's Order Sheet is acceptable) — MM/DD/YY — Date

G. I. M. Performing — Signature of Therapist Providing Treatment Providing Evaluation/Treatment — MM/DD/YY — Date

Mail To:

E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/SOIA

PRIOR AUTHORIZATION
SPELL OF ILLNESS ATTACHMENT
(Physical, Occupational, Speech Therapy)

1. Complete this form
2. Attach to PA/RF (Prior Authorization Request Form)
3. Mail to EDS

RECIPIENT INFORMATION

(1) LAST NAME	(2) FIRST NAME	(3) MIDDLE INITIAL	(4) MEDICAL ASSISTANCE ID NUMBER	(5) AGE
RECIPIENT	IM	A	123456739Ø	87

PROVIDER INFORMATION

(6) THERAPIST'S NAME AND CREDENTIALS	(7) THERAPIST'S MEDICAL ASSISTANCE PROVIDER NUMBER	(8) THERAPIST'S TELEPHONE NUMBER
I.M. PERFORMING, M.S.	12345678	(XXX) XXX - XXXX

(9) REFERRING/PRESCRIBING PHYSICIAN'S NAME: I.M. REFERRING

A. ☐ Physical Therapy SOI ☐ Occupational Therapy SOI ☑ Speech Therapy SOI

B. Provide a description of the recipient's diagnosis and problems. Indicate the functional regression which has occurred and the potential to reachieve the previous skill.

CEREBRAL PALSY SINCE BIRTH. SUFFERS FROM VASCULAR HYPERTENSION, DEGENERATIVE JOINT DISEASE, DIVERTICLOSIS OF COLON, SUBACUTE CHOLECYSTIS AND CHOLELITHIASIS.

C. Attach a copy of the recipient's Therapy Plan of Care, including a current evaluation.

D. What is the anticipated end date of the spell of illness.
MM/DD/YY

E. Supply the physician's dated signature on either the Therapy Plan of Care or the Physician's Order Sheet.

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

F. I.M. Prescribing — Signature of Prescribing Physician (A copy of the Physician's Order Sheet is acceptable) — mm/DD/YY Date

G. I.M. Performing — Signature of Therapist Providing Treatment Providing Evaluation/Treatment — mm/DD/YY Date

**INSTRUCTIONS FOR THE REQUEST
OF A THERAPY SPELL OF ILLNESS
(Physical, Occupational, Speech)**

A. Complete the Prior Authorization Request Form (PA/RF).

- Required Elements: 1-13, 16, 18, 19, 23 and 24
- Leave these Elements Blank: 14, 15, 17, 20 and 21
- Refer to the attached instructions for completing the Prior Authorization Request Form (PA/RF).

B. Complete the Prior Authorization Spell of Illness Attachment (PA/SOIA).

- Required Elements: 1-9 and Parts A thru G
- Refer to the attached instructions for completing the Spell of Illness Attachment (PA/SOIA).

C. Submit the Prior Authorization Request Form (PA/RF) and the Spell of Illness Attachment (PA/SOIA) to the following address:

E.D.S. Federal Corporation
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088